



Audiopedics, LLC □ Hearing Aids and Speech Therapy  
456 US Highway 22 Whitehouse Station, NJ 08889

### APPOINTMENT INFORMATION SHEET

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*For office use only:*

Diagnosis: \_\_\_\_\_

Procedure: \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_

Procedure Code: \_\_\_\_\_

#### Contact Information

Name of Patient (please print): \_\_\_\_\_

FIRST NAME    M.I.    LAST NAME

Name of Responsible Party (please print): \_\_\_\_\_

FIRST NAME    M.I.    LAST NAME

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Physician: \_\_\_\_\_

Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone Number of Primary Physician: \_\_\_\_-\_\_\_\_-\_\_\_\_

Home Address:

Street Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Phone Number (home): \_\_\_\_-\_\_\_\_-\_\_\_\_

Phone Number (cell): \_\_\_\_-\_\_\_\_-\_\_\_\_

E-mail: \_\_\_\_\_

Preferred Method of Communication:    home phone    |    cell phone    |    e-mail

Can we leave a voicemail message(circle one):    YES    NO

Party Responsible for Payment: \_\_\_\_\_

Relationship to the Insured (circle one):    Spouse    |    Parent    |    Guardian

Do you have Medicare, Medicaid, or Access?                    YES    NO



Insurance Information

Primary Insurance	Secondary Insurance
Insurance Name	Insurance Name
Address	Address
City	City
State                      Zip	State                      Zip
Provider Ph. #	Provider Ph. #
ID#	ID#
Group #	Group #
Policyholder's Name	Policyholder's Name
Policyholder's SS#	Policyholder's SS#
Policyholder's Date of Birth	Policyholder's Date of Birth
Subscriber's Employer	Subscriber's Employer

**INJURIES**

Work-related	Auto. Accidents
Date of Injury	
Ins. Co. Name	
Address	
City	
State                      Zip	
Representative's Name	
Phone #	

How did you hear about us? (check all that apply)

- advertising
  - Internet
  - direct mail / newspaper
  - event (lecture, sales promotion)
  - signs / local knowledge
  - other ( \_\_\_\_\_ )
- recommendation
  - doctor/institution
  - insurance
  - friends/family               Referral (Who) Card
  - non-physician professional (school, daycare, job)
  - other ( \_\_\_\_\_ )
- other ( \_\_\_\_\_ )